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BLOG & NEW POSTINGS

- March 4, 2016
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WHO PROFITS FROM ADDICTION/RECOVERY STIGMA?

The social stigma attached to addiction is most often portrayed as an attitudinal problem rooted in the lack of knowledge about alcohol, tobacco, and other drug (ATOD) problems and the prevalence and methods through which they are effectively resolved. The resulting antidotes thus become focused on public/professional education and changing attitudes through increased public contact with those who have experienced sustained recovery from such problems.

There is, however, another far more penetrating analysis that asked three provocative questions: 1) Who profits from the social stigma attached to ATOD problems? 2) What strategies and tactics are utilized to create, sustain, and intensify ATOD-related social stigma? 3) How could such stigma-promoting forces be reduced as part of the broader effort to humanize these problems and replace systems of ATOD coercion and control with systems of public compassion, professional care, and peer recovery support?

Answering the question of who profits from addiction/recovery-related stigma requires attending the mantra, "Follow the Money!" It is important to identify those individuals and institutions whose interests are served by ATOD-related stigma. There are five social institutions that directly or indirectly benefit from the stigma attached to addiction and addiction recovery.

The Media For nearly two centuries, American media outlets have fueled moral panics surrounding drug addiction. To garner the maximum amount of attention, media campaigns have demonized illicit drugs, illicit drug users, and illicit drug sellers—all while serving as the primary advertising vehicle for licit drugs. Eight themes permeate these cyclical, media-generated moral panics:

1. The drug is associated with a hated subgroup of the society or a foreign enemy.
2. The drug is identified as solely responsible for many problems in the culture, i.e., crime, violence, insanity.
3. The survival of the culture is pictured as being dependent on the prohibition of the drug.
4. The concept of "controlled" usage is destroyed and replaced by a "domino theory" of chemical progression.
5. The drug is associated with corruption of young children, particularly their sexual corruption.
6. Both the user and supplier of the drug are defined as fiends, always in search of new victims; usage of the drug is considered "contagious."
7. Policy options are presented as total prohibition or total access.
8. Anyone questioning any of the above assumptions is bitterly attacked and characterized as part of the problem that needs to be eliminated.

By its implicit categorization of "good drugs" and "bad drugs" and defining addiction as a problem of sin ("badness") rather than "sickness," the media has served as the primary purveyor of the social stigma attached to addiction. By using the most emotionally alarming language and the most lurid and fear-evoking images, media institutions have used addiction stories to serve their primary purpose, which is not to inform, but to garner public attention in order to promote and sell products to in turn sustain their own institutional profit and power. The American media has functioned as a stigma pimp, profiting on the prolonged emotional manipulation of the citizenry it claims to serve. Reducing addiction-related stigma does not serve its institutional interests; promoting and intensifying alarm through such stigma does.

The Criminal Justice Industrial Complex (CJIC) How alcohol and other drug problems are defined dictates problem ownership and who will receive the cultural resources allocated to address these problems. In short, the fate of professional careers, professional fields, and whole community economies hinge on such definitions. Any change in problem ownership poses significant threats to individuals, professions, and industrial economies. The twentieth century stigmatization, demedicalization, and intensified criminalization of drug problems created the largest expansion of the criminal justice system in American and world history. Once created, these ever-expanding social institutions—law enforcement, courts, jails and prisons, probation and parole services—and all the businesses relying upon these institutions become addicted to a set of stigma-imbedded beliefs and attitudes about drugs, drug users, and drug addiction. Any suggestion that drug users deserve compassion and care rather than punishment and control threatens to transfer billions of dollars in cultural resources to other social institutions—a move that those with vested interests in the status quo must aggressively resist to protect their own personal and institutional interests. Drug users—particularly poor men of color–are the raw materials that have fueled the expansion of the CJIC and economically rescued many rural white communities now supported by prison-based economies. The American criminal justice industrial complex and the community economies fed by this complex have profited handsomely from addiction-related stigma and can be expected to resist efforts to destigmatize, decriminalize, medicalize, and

humanize addiction-related problems and to lobby for increased drug penalties, mandatory minimum sentencing, three-strike laws, limited parole opportunities, and ease of parole revocation. Any reform efforts must actively manage such forces of resistance.

The Child Welfare System The moral panic surrounding prenatal cocaine exposure—and all the misinformation upon which it was based—led to the largest expansion of the child welfare system in the history of the United States. This and subsequent moral panics (e.g., methamphetamine, prescription opioids) led criminal justice and child welfare authorities to emerge as occupying armies within poor communities of color and in poor white communities. Once in this role, vested interests have prevented the dismantling of the beliefs upon which such institutional expansion was based. The child welfare system in the U.S. has yet to fully and publically acknowledge the harm it did to the children and families in response to the cocaine-focused moral panic of the 1980s. There has been no official apology or restitution effort from the leading institutions within the child welfare field. Nor has there been an acknowledgement that the child welfare system and those who worked in this system profited institutionally, professionally, and personally in the face of the harm to those they were pledged to serve.

The Alcohol, Tobacco, and Pharmaceutical (ATP) Industries. The licit drug industries in the United States have profited greatly from the stigma attached to licit and illicit drug addiction. Concepts, words, slogans, and images that portray addiction as a product of moral/character weakness or the biological vulnerability of a small subset of ATP consumers and portray America's drug problem in terms of illicit drugs and illicit drug markets draw attention from the harmfulness of ATP products and the exploitive marketing practices of the ATP industries. Moral panics over illicit drug use and caricatured images of addicted persons serve these industries well by hiding America's real addicts and obscuring her real drug pushers. The ATP industries have been well-served by caricatured images that bear little similarity to the mass of people whose lives have been severely harmed by the use of alcohol, tobacco, and licit drugs. The illicit drug industry also profits from social stigma. The foundation of its existence and its inordinate profits rests on the stigma attached to illicit drugs, the legal prohibition of these substances, and the resulting inflated drug prices and profits.

Specialty Sector Addiction Treatment It would seem on the surface that addiction treatment programs would be among the most vocal advocates for the destigmatization of addiction, addiction treatment, and addiction recovery. After all, stigma inhibits and slows help seeking and poses a major obstacle to community inclusion and quality of personal/family life in long-term addiction recovery. But in some ways, specialty sector addiction treatment owes its very existence to stigma. It exists because mainstream health and human service agencies historically viewed people with alcohol and other drug problems with contempt and as not morally worthy of compassion and care. The failure of these other systems to adequately respond to alcohol and other drug problems became the rationale for a specialized field of addiction treatment.

If ATOD problems, even the most severe, complex, and chronic of such problems, were truly destigmatized, it is quite likely that the treatment of these disorders would be fully integrated into the larger health care system– eroding the very foundation of specialty sector addiction treatment. We are currently witnessing the opening salvos in the tri-directional integration of addiction treatment, mental health treatment, and primary health care in the U.S. The resistance of specialty sector addiction treatment leaders to service integration could be based on legitimate concerns about the capacities of these other systems to effectively treat addiction, but it could also be based on the threats to personal, professional, and institutional interests that such integration poses.

If substance use disorders were to be fully destigmatized, one of the unexpected outcomes of that shift could be the dissipation of specialty sector addiction treatment in the United States and the resulting effects on institutional profits and professional careers. Any analysis of the role the addiction treatment field has played in promoting or exploiting stigma would also have to include a review of how addiction-related moral panics (and its stigma producing effects) have historically contributed to increased public and private funding for addiction treatment and the role treatment programs have played in fueling such moral panics.

Others Who May Profit from Stigma Social stigma attributed to one factor (e.g., addiction) may serve to mask or hide other attitudes that are no longer socially acceptable to publically express (e.g., racism, homophobia). I have

closely watched many of the NIMBY (Not in My Backyard) battles rising over the proposed location of a new treatment center facility or recovery home. I have witnessed groups of advocates of the new facility faced off against vocal neighborhood representatives opposing the location of the new facility. On numerous occasions, I have been struck by the heterogeneity of the former (e.g., racial diversity, diversity of sexual orientation and gender identity, religious diversity) and the homogeneity (e.g., whiteness) of the latter. To what extent does the expression of addiction-related stigma now serve as a proxy for, or a mask to hide, other forms of less socially acceptable prejudice?

Counterstrategies Effective efforts to address the social stigma attached to addiction and recovery must move beyond educational strategies aimed at changing personal attitudes of the public. They must include strategies that:

- Expose and document the extent to which individuals, organizations, business sectors, and community economies profit from the perpetuation of stigma,
- Mobilize grassroots and institutional constituencies that can counter such forces (see for example the work of Stop Stigma Now),
- Create financial and institutional incentives (via preferential patronage, public praise) for "getting it right" and disincentives for getting it wrong (via boycotts, public condemnation, and legal redress), and
- Support alternative strategies of economic development for professional guilds and local communities that have profited from stigma-fueled industries.

Those of us committed to ameliorating the social stigma attached to addiction and addiction recovery must engage in serious explorations of these three critical questions: 1) Who profits from the social stigma attached to ATOD problems? 2) What strategies and tactics are utilized to create, sustain, and intensify ATOD-related social stigma? 3) How could such stigma-promoting forces be reduced as part of the broader effort to humanize these problems and replace systems of ATOD coercion and control with systems of public compassion, professional care, and peer recovery support?

Post Date March 4, 2016 by Bill White